TIANO O'DELL PLLC
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August 21, 2019

Via Certified Mail #7016 3010 0000 9010 7489

U.S. Dept. of Veterans Affairs
Office of Chief Counsel
251 North Main Street
Winston-Salem, NC 27155

RE: My Client: Estate of Felix K. McDermott

Dear Madam or Sir:

Enclosed please find the following documents:

- Form SF95, including separate "Basis of Claim";
- Letter of Administration;
- Autopsy Report;
- Funeral bill;
- Death Certificate.

If you have any questions or concerns, please do not hesitate to contact my office.

Very truly yours,

Tony O'Dell

TLO/tlb

Enclosures

CLAIM FOR DAMAGE, INJURY, OR DEATH

INSTRUCTIONS: Please read carefully the instructions on the reverse side and supply information requested on both sides of this form. Use additional sheet(s) if necessary. See reverse side for additional instructions.

FORM APPROVED
OMB NO. 1105-0008

1. Submit to Appropriate Federal Agency:	2. Name, address of claimant, and claimant's personal representative if any. (See instructions on reverse). Number, Street, City, State and Zip code.
U.S. Dept. of Veterans Affairs Office of Chief Counsel 251 North Main Street Winston-Salem, NC 27155	Melanie Proctor, as Admin. of Estate of Felix K. McDermott, 1270 McKim Creek Rd., Ellenboro, WV 26346 - appt paper Tony O'Dell, Esq., Tiano O'Dell, PLLC, P.O. Box 11830, 118 Capitol St., Charleston, WV 25539

3. TYPE OF EMPLOYMENT	4. DATE OF BIRTH	5. MARITAL STATUS	6. DATE AND DAY OF ACCIDENT	7. TIME (A.M. OR P.M.)
☐ MILITARY ☒ CIVILIAN	11/16/1935	Widower	04/09/2018 Monday	1:00 am

8. BASIS OF CLAIM (State in detail the known facts and circumstances attending the damage, injury, or death, identifying persons and property involved, the place of occurrence and the cause thereof. Use additional pages if necessary).

See attached "Basis of Claim".

9. **PROPERTY DAMAGE**

NAME AND ADDRESS OF OWNER, IF OTHER THAN CLAIMANT (Number, Street, City, State, and Zip Code).

Not applicale

BRIEFLY DESCRIBE THE PROPERTY, NATURE AND EXTENT OF THE DAMAGE AND THE LOCATION OF WHERE THE PROPERTY MAY BE INSPECTED. (See instructions on reverse side).

Not applicable

10. **PERSONAL INJURY/WRONGFUL DEATH**

STATE THE NATURE AND EXTENT OF EACH INJURY OR CAUSE OF DEATH, WHICH FORMS THE BASIS OF THE CLAIM. IF OTHER THAN CLAIMANT, STATE THE NAME OF THE INJURED PERSON OR DECEDENT.

Personal Injury/Wrongful death - Felix McDermott was given an injection of insulin that he did not need and that was not ordered for him which caused him to develope severe refractory hypoglycemia, which after several hours caused his death.

11. **WITNESSES**

NAME	ADDRESS (Number, Street, City, State, and Zip Code)
Paul Uribe, Deputy Medical Examiner of the Armed Forces Medical Examiner System	115 Purple Heart Drive, Dover AFB, Delaware, 19902

12. (See instructions on reverse). **AMOUNT OF CLAIM** (in dollars)

12a. PROPERTY DAMAGE	12b. PERSONAL INJURY	12c. WRONGFUL DEATH	12d. TOTAL (Failure to specify may cause forfeiture of your rights).
0.00	1,000,000	5,000,000	6,000,000

I CERTIFY THAT THE AMOUNT OF CLAIM COVERS ONLY DAMAGES AND INJURIES CAUSED BY THE INCIDENT ABOVE AND AGREE TO ACCEPT SAID AMOUNT IN FULL SATISFACTION AND FINAL SETTLEMENT OF THIS CLAIM.

13a. SIGNATURE OF CLAIMANT (See instructions on reverse side).	13b. PHONE NUMBER OF PERSON SIGNING FORM	14. DATE OF SIGNATURE
Melanie Proctor	304-758-5053 304-720-6700	8/20/19

CIVIL PENALTY FOR PRESENTING FRAUDULENT CLAIM	CRIMINAL PENALTY FOR PRESENTING FRAUDULENT CLAIM OR MAKING FALSE STATEMENTS
The claimant is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages sustained by the Government. (See 31 U.S.C. 3729).	Fine, imprisonment, or both. (See 18 U.S.C. 287, 1001.)

INSURANCE COVERAGE

In order that subrogation claims may be adjudicated, it is essential that the claimant provide the following information regarding the insurance coverage of the vehicle or property.

15. Do you carry accident Insurance? ☐ Yes If yes, give name and address of insurance company (Number, Street, City, State, and Zip Code) and policy number. ☒ No

16. Have you filed a claim with your insurance carrier in this instance, and if so, is it full coverage or deductible? ☐ Yes ☒ No

17. If deductible, state amount.

0.00

18. If a claim has been filed with your carrier, what action has your insurer taken or proposed to take with reference to your claim? (It is necessary that you ascertain these facts).

Not applicable

19. Do you carry public liability and property damage insurance? ☐ Yes If yes, give name and address of insurance carrier (Number, Street, City, State, and Zip Code). ☒ No

INSTRUCTIONS

Claims presented under the Federal Tort Claims Act should be submitted directly to the "appropriate Federal agency" whose employee(s) was involved in the incident. If the incident involves more than one claimant, each claimant should submit a separate claim form.

Complete all items - Insert the word NONE where applicable.

A CLAIM SHALL BE DEEMED TO HAVE BEEN PRESENTED WHEN A FEDERAL AGENCY RECEIVES FROM A CLAIMANT, HIS DULY AUTHORIZED AGENT, OR LEGAL REPRESENTATIVE, AN EXECUTED STANDARD FORM 95 OR OTHER WRITTEN NOTIFICATION OF AN INCIDENT, ACCOMPANIED BY A CLAIM FOR MONEY DAMAGES IN A **SUM CERTAIN** FOR INJURY TO OR LOSS OF PROPERTY, PERSONAL INJURY, OR DEATH ALLEGED TO HAVE OCCURRED BY REASON OF THE INCIDENT. THE CLAIM MUST BE PRESENTED TO THE APPROPRIATE FEDERAL AGENCY WITHIN **TWO YEARS** AFTER THE CLAIM ACCRUES.

Failure to completely execute this form or to supply the requested material within two years from the date the claim accrued may render your claim invalid. A claim is deemed presented when it is received by the appropriate agency, not when it is mailed.

If instruction is needed in completing this form, the agency listed in item #1 on the reverse side may be contacted. Complete regulations pertaining to claims asserted under the Federal Tort Claims Act can be found in Title 28, Code of Federal Regulations, Part 14. Many agencies have published supplementing regulations. If more than one agency is involved, please state each agency.

The claim may be filled by a duly authorized agent or other legal representative, provided evidence satisfactory to the Government is submitted with the claim establishing express authority to act for the claimant. A claim presented by an agent or legal representative must be presented in the name of the claimant. If the claim is signed by the agent or legal representative, it must show the title or legal capacity of the person signing and be accompanied by evidence of his/her authority to present a claim on behalf of the claimant as agent, executor, administrator, parent, guardian or other representative.

If claimant intends to file for both personal injury and property damage, the amount for each must be shown in item number 12 of this form.

The amount claimed should be substantiated by competent evidence as follows:

(a) In support of the claim for personal injury or death, the claimant should submit a written report by the attending physician, showing the nature and extent of the injury, the nature and extent of treatment, the degree of permanent disability, if any, the prognosis, and the period of hospitalization, or incapacitation, attaching itemized bills for medical, hospital, or burial expenses actually incurred.

(b) In support of claims for damage to property, which has been or can be economically repaired, the claimant should submit at least two itemized signed statements or estimates by reliable, disinterested concerns, or, if payment has been made, the itemized signed receipts evidencing payment.

(c) In support of claims for damage to property which is not economically repairable, or if the property is lost or destroyed, the claimant should submit statements as to the original cost of the property, the date of purchase, and the value of the property, both before and after the accident. Such statements should be by disinterested competent persons, preferably reputable dealers or officials familiar with the type of property damaged, or by two or more competitive bidders, and should be certified as being just and correct.

(d) **Failure to specify a sum certain will render your claim invalid and may result in forfeiture of your rights.**

PRIVACY ACT NOTICE

This Notice is provided in accordance with the Privacy Act, 5 U.S.C. 552a(e)(3), and concerns the information requested in the letter to which this Notice is attached.

A. *Authority:* The requested information is solicited pursuant to one or more of the following: 5 U.S.C. 301, 28 U.S.C. 501 et seq., 28 U.S.C. 2671 et seq., 28 C.F.R. Part 14.

B. *Principal Purpose:* The information requested is to be used in evaluating claims.

C. *Routine Use:* See the Notices of Systems of Records for the agency to whom you are submitting this form for this information.

D. *Effect of Failure to Respond:* Disclosure is voluntary. However, failure to supply the requested information or to execute the form may render your claim "invalid."

PAPERWORK REDUCTION ACT NOTICE

This notice is solely for the purpose of the Paperwork Reduction Act, 44 U.S.C. 3501. Public reporting burden for this collection of information is estimated to average 6 hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Director, Torts Branch, Attention: Paperwork Reduction Staff, Civil Division, U.S. Department of Justice, Washington, DC 20530 or to the Office of Management and Budget. Do not mail completed form(s) to these addresses.

BASIS OF CLAIM

On April 9, 2018, Felix Kirk McDermott, a patient at the Louis A. Johnson VA Medical Center in Clarksburg, WV (hereinafter sometimes referred to as "VAMC") died as a result of the VAMC breaching its affirmative duty to keep him safe when he was foreseeably injected with a fatal dose of insulin, either negligently or willfully, by an unidentified person while he was an admitted patient of the VAMC. Regardless of the relationship of this unidentified person to VAMC, if any, the VAMC still had an independent duty to protect its patients, including Ret. Army Sgt. McDermott, from foreseeable harm once it knew or should have known that its patients were being wrongfully injected with insulin. Under the facts of this case, the VAMC breached its independent and affirmative duty or protect Ret. Army Sgt. McDermott from foreseeable harm, and as a direct and proximate result of that breach, Ret. Army Sgt. McDermott died. Moreover, if the unidentified person who injected Ret. Army Sgt. McDermott with insulin was an employee, and if this person injected Ret. Army Sgt. McDermott willfully with insulin with an intent to harm him, this act was not committed within the scope of her/his employment with the VAMC/U.S. Government. If the insulin was injected into Ret. Army Sgt. McDermott negligently, then the VAMC is also responsible because the negligence of its employee is imparted onto the VAMC.

Upon information and belief, before April 9, 2018, nine or ten patients of the Louis A. Johnson VA Medical Center in Clarksburg, WV, had died expectedly as a result of unexplained severe hypoglycemia, a/k/a low blood sugar. The employees of the VAMC were aware of each of the unexpected and suspicious deaths. Each of these nine or ten patients had received a large and wrongful injection of insulin in the abdomen that was neither ordered by a doctor or medically necessary. The employees of the VAMC either knew, or should have known, of the wrongful

insulin injections to each of nine or ten patients who died as a result of wrongful insulin injections. Therefore, as of April 6, 2018, when Ret. Army Sgt. McDermott was admitted to the VAMC, there was a reasonably foreseeable risk of harm that more VAMC patients would become victims of the wrongful insulin injections unless the VAMC took affirmative action to protect the VAMC's patients from such foreseeable and wrongful conduct. As a U.S. Veteran hospital, the VAMC had a special relationship with its veteran patients that created an affirmative duty to protect those patients from reasonably foreseeable harm. The VAMC had an affirmative duty to ensure that Ret. Army Sgt. McDermott received high-quality and timely healthcare services in compliance with the standard of care. In this case, the VAMC took custody of Ret. Army Sgt. McDermott, who suffered from dementia and physical disability due to a previous stroke and the VAMC had an affirmative duty to keep him safe. Therefore, there is undoubtedly a special relationship between the VAMC and Ret. Army Sgt. McDermott under the facts of this case. Under West Virginia law, foreseeability is the "primary factor" in determining whether a duty exists. *Robertson v. LeMaster*, 171 W. Va. 607, 301 S.E.2d 563 (1983). The "*ultimate test* of the existence of a duty to use care is found in the *foreseeability* that harm may result if it is not exercised." Syl. Pt. 8, *Aikens v. Debow*, 208 W.Va. 486, 541 S.E.2d 576, 579 (2000) (citing Syl. Pt. 3, *Sewell v. Gregory,* 179 W. Va. 585, 371 S.E.2d 82 (1988)). West Virginia law also requires caregivers, like the VAMC, who accept responsibility for the care of incapacitated elderly people, to protect them from harm.

At the time of Ret. Army Sgt. McDermott's death, nobody at the medical center told his family about the sudden and unexplained hypoglycemia that caused his death. Nor were the family members told that prior to Ret. Army Sgt. McDermott's death, nine or ten other patients at the facility had suffered similar unexplained deaths due to sudden onset of unexplained medical conditions. It was not until months later that government investigators contacted Ret. Army Sgt.

McDermott's daughter Melanie Proctor and advised her of the earlier deaths and their belief that her father's death was not a result of natural causes.

McDermott's Admission and Initial Treatment at the Louis A. Johnson VA Medical Center

Felix Kirk McDermott was a Vietnam Veteran, a retired sergeant after 20 years of active U.S. Army service and subsequently a member of the Pennsylvania National Guard, who was admitted to the Louis A. Johnson VA Medical Center in Clarksburg, WV, on April 6, 2018. Ret. Army Sgt. McDermott came to the facility because he had aspirated on some food and developed aspiration pneumonia. During his initial stay at the facility, Ret. Army Sgt. McDermott's health condition improved.

Ret. Army Sgt. McDermott did not suffer from diabetes. Ret. Army Sgt. McDermott had never been diagnosed with diabetes. Ret. Army Sgt. McDermott did not have a history of ever taking oral medication or insulin injections for diabetes. During his treatment at the VAMC, Ret. Army Sgt. McDermott had his blood glucose levels monitored daily via a fingerstick blood test. Ret. Army Sgt. McDermott's daily fingerstick blood glucose levels were within the normal range of 100-181 mg/dL. There was no medical need for Ret. Army Sgt. McDermott to receive or take insulin and there were no physician orders for insulin during Ret. Army Sgt. McDermott's April 2019 hospitalization.

McDermott's Unexplained Sudden Health Decline and Death

In the early morning hours of April 9, 2018, while still a patient at the Louis A. Johnson VA Medical Center, Ret. Army Sgt. McDermott unexpectedly developed shortness of breath. A fingerstick blood glucose test revealed that Ret. Army Sgt. McDermott had a critically and profoundly low blood sugar level of just 12 mg/dL. Low blood sugar is also called hypoglycemia.

Ret. Army Sgt. McDermott's severely low blood sugar level was so low, that medical efforts to raise his blood sugar level back to normal were unsuccessful. His condition continued to worsen, and he died from severe hypoglycemia at roughly 9:00 a.m. on the morning of April 9, 2018. Employees of the VAMC never explained to Ret. Army Sgt. McDermott's family the unexplained diagnosis of hypoglycemia. Ret. Army Sgt. McDermott's family was only advised of his death. Ret. Army Sgt. McDermott's family had his body sent to a funeral home and prepared for burial. Felix Kirk McDermott was buried on April 13, 2018.

Subsequent Investigation

Under the jurisdiction of the VA Office of the Inspector General, Ret. Army Sgt. McDermott's remains were disinterred on October 23, 2018 and sent to Dover Air Force Base for autopsy because of the suspicious manner of Mr. Dermott's death. During its investigation, VA investigators advised Melanie Proctor, Ret. Army Sgt. McDermott's daughter and the administratrix of his estate, that there was evidence that nine or ten other patients of the Louis A. Johnson VA Medical Center had been wrongfully injected with insulin in their abdomen, thereby causing their deaths. Ms. Proctor was further advised that her father was one of the last known victims.

Exhumation and Autopsy

The exhumation and autopsy confirmed investigators' suspicions that Ret. Army Sgt. McDermott had received an exogenous insulin shot in the left side of his abdomen. That finding was consistent with the clinical history of a profound hypoglycemic event that occurred the morning of April 9, 2018. The autopsy report confirmed that Ret. Army Sgt. McDermott was not a diabetic and had no history of oral hypoglycemic use or previous insulin administration. The

autopsy report also confirmed there were no hospital orders for the administration of insulin. The autopsy report noted that despite Ret. Army Sgt. McDermott's pre-existing health issues, he was showing clear improvement in his medical condition when he was negligently, wrongfully, or intentionally injected with insulin.

Autopsy Findings and VA Investigation

As a result of the investigation, the Armed Forces Medical Examiner ruled that the manner of Felix Kirk McDermott's death is homicide. If the medical examiner's conclusion is correct, Felix Kirk McDermott was murdered while he was in the care and custody of the Louis A. Johnson VA Medical Center despite the VAMC being on notice of the previous wrongful injections. Ret. Army Sgt. McDermott's family has been advised that the VA investigators have a person of interest in the deaths of the multiple VAMC patients. As of the submission of this claim form, that person's identity has not been shared with Ret. Army Sgt. McDermott's family.

The VAMC's Duty and Breach of Duty

Nine or ten other VAMC patients inexplicably died before Ret. Army Sgt. McDermott became a similar fatality victim. These nine or ten prior deaths created an antecedent, independent and affirmative duty to act to protect Ret. Army Sgt. McDermott and other VAMC patients from foreseeable harm before Ret. Army Sgt. McDermott was also wrongfully injected with insulin and killed. The VAMC breached this affirmative duty and was negligent in multiple ways: by failing to thoroughly investigate each of these suspicious deaths and discover the cause of those deaths which resulted from the unwarranted injection of insulin by the unidentified person; by failing to alert Ret. Army Sgt. McDermott or his family that multiple other VAMC patients at the Louis A. Johnson VA Medical Center had died suspiciously; by failing to adequately staff its medical center; by failing to designate each of the other nine or ten deaths as sentinel events despite each

of those deaths meeting the criteria to be designated as a sentinel event, and by failing to identify, report and investigate each sentinel event as required by the standard of care; by failing to initiate a root cause analysis after each of the nine or ten other deaths in order to prevent additional deaths and reduce the potential for patient harm; by failing to have proper reconciliation of medications, including insulin; by failing to have proper oversight by senior VAMC management staff; by failing to properly train VAMC staff; and by failing to warn Ret. Army Sgt. McDermott and his family of other nine or ten deaths. If Ret. Army Sgt. McDermott or his family had been so apprised and properly warned, they could have made an informed choice about whether to seek care at that facility. Due to the negligent concealment of those other suspicious deaths and information, neither Ret. Army Sgt. McDermott nor his family had an opportunity to choose. Moreover, had the VAMC not acted negligently as described above, Ret. Army Sgt. McDermott's untimely death would have been prevented.

The VAMC had a duty to provide reasonable and competent medical care to its patients, including Felix Kirk McDermott. Ret. Army Sgt. McDermott had an absolute right to be free from abuse by the staff at the facility. The VAMC had a duty to protect and prevent its patients, including Ret. Army Sgt. McDermott, from being administered drugs and injections that were not medically necessary. The VAMC had a duty to properly screen and hire its employees. The VAMC had a duty to thoroughly investigate the cause of suspicious and unexpected deaths in order to prevent additional patients, including Ret. Army Sgt. McDermott, from being exposed to the unreasonable risk of being injected with medications meant to harm them. The VAMC had a duty to warn patients of the multiple, suspicious and unexpected deaths so that new patients, including Ret. Army Sgt. McDermott, could make an informed decision about whether to seek care there. The VAMC had a duty not to conceal from patients the multiple, suspicious and unexpected deaths so

that new patients, such as Ret. Army Sgt. McDermott, could make an informed decision about whether to seek care there. The VAMC had a duty to keep good control of its drugs and inventory, including injectable insulin, so that employees of the Louis A. Johnson VA Medical Center did not have unaccounted for access to drugs and injections that could be misused or abused. The VAMC had a duty to properly supervise its employees and not to retain employees that were a danger to patients. Each of these affirmative duties of the VAMC were antecedent and independent of the conduct of person who wrongfully injected Ret. Army Sgt. McDermott.

The VAMC breached each of the above listed duties, which breaches were deviations from the appropriate standard of medical care and were a proximate cause of Ret. Army Sgt. McDermott's injuries and death. As a result of those deviations from the appropriate standard of care, Ret. Army Sgt. McDermott was exposed to unnecessary, foreseeable and preventable dangers, and it was those deviations by the VAMC that were a proximate cause of his death. In addition, if the employee of the Louis A. Johnson VA Medical Center who wrongfully injected Ret. Army Sgt. McDermott in the abdomen with insulin did so negligently, then such negligence is also deviation from the appropriate standard, and the VAMC is responsible for the negligence of its employees under *respondeat superior*.

Monetary Damages and Claim for Relief

As a direct and proximate result of deviations from the appropriate standards of medical care described herein which caused Ret. Army Sgt. McDermott's injuries and wrongful death, his statutory beneficiaries are entitled to all non-economic and economic damages allowed under West Virginia law, including sorrow, mental anguish, and solace which may include society, companionship, comfort, guidance, kindly offices and advice of the decedent, pain and suffering,

mental anguish, funeral costs of $7,500 and loss of income to Ret. Army Sgt. McDermott's Estate of approximately $2,200 per month throughout the remainder of his natural life.

Attachments

1. Letter of Administration from the Tyler County, WV, Commission appointing Melanie Proctor as the Administratrix of the Estate of Felix Kirk McDermott dated July 27, 2018.
2. Autopsy Report of Felix Kirk McDermott dated February 13, 2019 from the U.S. Department of Defense's Armed Forces Medical Examiner System
3. Funeral Bill for the funeral of Felix Kirk McDermott
4. Death Certificate of Felix Kirk McDermott file number 007446.

United States of America

State of West Virginia

County of Tyler, ss:

Letter of Administration

Estate of FELIX KIRK MCDERMOTT

I, NEIL A. ARCHER II, Clerk of the Tyler County Commission, in the State of West Virginia, do hereby certify that MELANIE PROCTOR was on the 27th day of July, 2018, appointed by the Tyler County Commission as administratrix(s) of the Estate of FELIX KIRK MCDERMOTT, duly qualified as such by taking oath prescribed by law, and by giving approved bond in the sum of $100.00, as required by law.

NOW THEREFORE, be it known that said appointment is now in full force and effect and that full faith and credit are due and should be given to all the acts of the said MELANIE PROCTOR as such administratrix(s) of the Estate of FELIX KIRK MCDERMOTT, as well in all jurisdictions, as elsewhere.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed the seal of the Tyler County Commission at my office in said County on the 27th day of July, 2018.

Neil A. Archer II

NEIL A. ARCHER II
Clerk of the Tyler County Commission

By Jennifer Minger

Jennifer Minger
Deputy Clerk

Armed Forces Medical
Examiner System

DEFENSE HEALTH AGENCY
115 PURPLE HEART DRIVE
DOVER AIR FORCE BASE, DELAWARE 19902

AUTOPSY REPORT

Autopsy Number: ME18-0260
Name: McDermott, Felix Kirkland
Grade: Retiree, US Army
Date of Birth: 16 November 1935
Date of Death: 9 April 2018
Place of Death: Louis A. Johnson VA Medical Center, Clarksburg, WV
Date/Time of Autopsy: 24 October 2018 @ 0730
Place of Autopsy: Dover AFB, DE
Date Report Signed: 13 February 2019

Circumstances of Death: By report, this Retiree was admitted to the Louis A. Johnson VA Medical Center on 6 April 2018. He was diagnosed with aspiration pneumonia and his condition was improving and had daily fingerstick blood glucose levels of 100-181 mg/dL from 6-8 April 2018. In the early morning of 9 April 2018, he developed severe shortness of breath and acute severe hypoglycemia. His initial finger stick blood glucose was 12 mg/dL (laboratory confirmation of 30 mg/dL at 0217) and the hypoglycemia was refractory to multiple ampules of D50 solution and 5% dextrose intravenous solution. Due to his deteriorating clinical condition, he was placed on comfort care measures and he passed away later that morning at 0900. Under jurisdiction of the VA Office of the Inspector General, the remains were disinterred on 23 October 2018 and brought to Dover AFB for autopsy.

Authorization for Autopsy: Armed Forces Medical Examiner, IAW 10 USC 1471.

Identification: Presumptive identification is made by a hospital identification band around the right wrist. A DNA sample is retained for record.

CAUSE OF DEATH: **Exogenous insulin administration.**

OTHER CONTRIBUTING FACTORS: Aspiration pneumonia, chronic obstructive pulmonary disease, dementia, hypertensive atherosclerotic cardiovascular disease.

MANNER OF DEATH: **Homicide.**

EXTERNAL EXAMINATION

The body is received in a gray casket. The body is clad in the clothing listed below. A hospital identification band labeled with the deceased's demographic information is attached to the right wrist.

The body is that of a partially decomposed embalmed male. The body is 69 inches in length and weighs 150 pounds. Injuries are described in the section "Evidence of Injury" and medical therapy is described in the section "Medical Intervention." Rigor is absent. There is partial fixed lividity on the posterior surface of the body except in the areas exposed to pressure. There is marked decomposition with mold growth, tan-brown skin discoloration, and partial adipocere formation of the head, neck, upper torso, both forearms and hands, and both lower extremities distal to the lower thigh. There is mummification of the head, both distal forearms, both hands, both legs, and both feet. There is partial adipocere formation with marked distal desiccation of the extremities. There is evidence of post-mortem insect activity with marked amounts of deceased flies and moderate live insect activity. The lower anterior and posterior torso are relatively preserved with mild amounts of skin sloughing and brown-black skin discoloration.

The head is mummified with relative sparing of the posterior scalp. The scalp hair is brown-gray and measures up to 1 1/4 inch in greatest length. Facial hair is not identified. Plastic eye covers underlie mummified eyelids; the orbits are otherwise empty. The ears are mummified. The nasal skeleton and maxilla are palpably intact. The external nares are free of abnormal secretions. The lips are mummified and without evident injury. The mouth is sutured closed; removal of the suture demonstrates deceased insects in the oral cavity. The teeth are absent. There is a 1 1/2 x 1/4 inch defect on the right side of the neck with suture material and underlying packing material, consistent with embalming. The chest demonstrates no external evidence of injury to the ribs and sternum. The abdomen is mildly protuberant with a 1/4 inch embalming port in the right upper quadrant of the abdomen. The genitalia are those of an adult male. The anus and perineum are unremarkable. The extremities show no evidence of fractures. The fingernails are intact. No scars are noted. Tattoos are noted on the right arm and left arm.

CLOTHING AND PERSONAL EFFECTS

The body is clad in a green Army service jacket (with medal rack and Airborne pin), black tie, green shirt, white underwear, green service pants, and black socks. A plastic undergarment covers the abdomen and proximal lower extremities. Plastic sleeves are on both arms. The clothing has moderate mold growth. The body is received with a green blanket and white sheet.

MEDICAL INTERVENTION

There is no evidence of acute medical or surgical intervention.

RADIOGRAPHS

Postmortem radiographs are obtained and show no radiographic evidence of acute traumatic injury. There is a benign ossification of the right iliac bone that extends posteriorly to the hip joint.

EVIDENCE OF INJURY

A 1 3/4 x 1 inch area of ecchymosis on the left lower abdomen with an underlying 4 x 2 centimeter area of superficial hemorrhage within the subcutaneous adipose tissue (see "Microscopic Examination" slide 14).

INTERNAL EXAMINATION

BODY CAVITIES:

The body is opened by the usual thoracoabdominal incision and the chest plate is removed. The ribs, sternum, and vertebral bodies are visibly and palpably intact. There is approximately 100 milliliters of decomposition fluid in each of the pleural cavities and approximately 50 milliliters of decomposition fluid in the peritoneal cavity. There is a 3 x 3 inch abdominal mesh on the peritoneal surface of the anterior abdominal wall. The thoracic organs are firm and mildly discolored, consistent with previous embalming.

HEAD (CENTRAL NERVOUS SYSTEM) and NECK:

The scalp is desiccated. There are no skull fractures. The dura mater and falx cerebri are intact and the brain is completely autolyzed. There is no epidural, subdural or subarachnoid hemorrhage present. The atlanto-occipital joint is stable. The autolyzed brain weighs 860 grams.

The neck is partially desiccated. The anterior strap muscles of the neck are homogenous and red-brown, without hemorrhage. The thyroid cartilage and hyoid bone are intact. The larynx is lined by intact mucosa and contains deceased insects.

CARDIOVASCULAR SYSTEM:

The heart is contained in an intact pericardial sac. The epicardial surface is smooth. The coronary arteries are present in a normal distribution and demonstrate focal narrowing of the left anterior descending coronary artery (75% occluded); the remaining coronary arteries are widely patent. The myocardium is firm and homogenous. The valve leaflets are thin and mobile. The walls of the left ventricle, interventricular septum, and right ventricle measure 1.8, 2.1, and 0.5 centimeters thick, respectively. The endocardium is smooth and glistening. The aorta gives rise to three intact and patent arch vessels and has moderate to marked calcific atherosclerosis, greatest at the iliac bifurcation. The renal and mesenteric vessels are unremarkable. The vena cavae and its major tributaries return to the heart in the usual distribution and are free of thrombi. The heart weighs 540 grams.

RESPIRATORY SYSTEM:

The upper airway is free of abnormal secretions. The mucosal surfaces are smooth, intact, and unremarkable. The pleural surfaces are smooth, glistening, and unremarkable bilaterally. The pulmonary parenchyma is diffusely congested, exuding slight amounts of bloody fluid with a 0.6 centimeter benign calcification in the left lower lobe. No other focal lesions are noted. The pulmonary arteries are normally developed and patent without thrombus or embolus. The right and left lungs weigh 640 and 620 grams, respectively.

HEPATOBILIARY SYSTEM:

The liver has an intact, smooth capsule covering brown parenchyma with no focal lesions noted. The gallbladder contains approximately 1 milliliter of bile and no stones. The extrahepatic biliary tree is patent. The liver weighs 900 grams.

GASTROINTESTINAL SYSTEM:

The esophagus is lined by smooth, intact mucosa. The stomach, small bowel, and colon are unremarkable. The stomach is empty. The pancreas is firm and pink-tan with no masses or nodules identified. The appendix is present.

GENITOURINARY SYSTEM:

The renal capsules are smooth, thin, and strip with ease from the underlying granular, red-brown cortical surfaces. The cortices are sharply delineated from the medullary pyramids. The left renal pelvis is mildly dilated. The calyces and ureters are unremarkable. The bladder contains no urine. The testes and prostate gland are unremarkable. The right and left kidneys weigh 160 grams each.

LYMPHORETICULAR SYSTEM:

Lymph nodes in the hilar, peri-aortic and iliac regions are not enlarged. The 180 gram spleen has a smooth, intact capsule covering red-purple parenchyma.

ENDOCRINE SYSTEM:

The pituitary gland is autolyzed. The thyroid gland is not identified. The right and left adrenal glands are symmetric, with bright yellow cortices, red-brown medullae, and no masses or areas of hemorrhage identified.

MUSCULOSKELETAL SYSTEM:

There is a benign ossification of the right iliac bone that extends posteriorly to the hip joint (identified radiographically, see "Radiographs"). No other abnormalities of muscle or bone are identified.

MICROSCOPIC EXAMINATION

Selected portions of organs are retained in formalin with the preparation of slides.

Slide 1 (pancreas): section demonstrates preserved pancreatic tissue with appropriate islet formation. Immunohistochemical staining for insulin demonstrates appropriate insulin staining within the islet cells with appropriate positive and negative internal controls with no discernable embalming artifacts.

Slide 2 (lung, right upper lobe), slide 3 (lung, right middle lobe), slide 4 (lung, right lower lobe), slide 5 (lung, left upper lobe), and slide 6 (lung, left lower lobe): sections of the lungs demonstrate scattered intra-alveolar and interstitial acute and chronic inflammation to include occasional multinucleated giant cells (greatest in the left upper lobe), and diffuse emphysematous changes with anthracosis deposition.

Slide 7 (kidney): section shows moderate glomerulosclerosis. mild hyaline arteriolosclerosis. and patchy interstitial nephritis.

Slide 8 (spleen): section shows appropriate lymphoid follicle formation.

Slide 9 (liver): section shows mild periportal fibrosis and periportal bile duct proliferation.

Slide 10 (left anterior descending coronary artery): section shows an arterial vessel occluded with calcific atherosclerosis and intimal thickening (degree of narrowing unable to be determined due to incomplete sectioning).

Slide 11 (heart. lateral left ventricle), slide 12 (heart, ventricular septum), and slide 13 (heart, right ventricle): sections show scattered myocyte hypertrophy, scattered focal areas of interstitial fibrosis. and a focal area of organizing granulation tissue of the septum.

Slide 14 (skin and soft tissue. left abdomen): section shows autolytic skin with underlying subcutaneous hemorrhage. Immunohistochemical staining for insulin demonstrates scattered granular positivity within the periphery of lipocytes and the interstitium. Polarization demonstrates scattered birefringent crystals. some of which stain positive for insulin.

ADDITIONAL REMARKS

1. Documentary photographs are taken by an AFMES Mortuary Affairs Specialist (92M). Representatives from the FBI and VAOIG attended the autopsy. A complete list of all individuals in attendance is on file.
2. Selected portions of organs and fluids are retained for toxicology and/or DNA identification.
3. Personal effects are released with the body.
4. No evidence is recovered at autopsy.

FINAL AUTOPSY DIAGNOSES

I. **Evidence of exogenous insulin administration:**
   A. Area of subcutaneous hemorrhage in the left abdomen with histologic and immunohistochemical findings consistent with subcutaneous insulin injection.
   B. Episode of severe hypoglycemia refractory to multiple ampules of D50 solution and 5% dextrose intravenous solution (initial finger stick blood glucose of 12 with laboratory confirmation of 30 mg/dL) in the early morning of 9 April.
   C. No hospital record of insulin administration or physician/nursing order for subcutaneous insulin injection.
   D. No medical history of diabetes, use of oral hypoglycemic agents, or previous insulin administration.

II. **Other contributing factors:**
   A. Hypertensive atherosclerotic cardiovascular disease:
      1. Focal severe atherosclerotic cardiovascular disease with 75% occlusion of the left anterior descending coronary artery.
      2. Moderate to marked calcific atherosclerosis of the aorta and proximal iliac arteries.
      3. Cardiomegaly with left ventricular hypertrophy.
      4. Kidneys with gross nephrosclerosis, consistent with hypertension.
   B. Lungs with emphysematous changes and histologic evidence of pneumonia, consistent with clinical history of chronic obstructive pulmonary disease and aspiration pneumonia.

III. **Medical history of clinical dementia.**

IV. **Postmortem artifacts/alterations: previous embalming with marked decomposition of the head, neck and distal extremities.**

V. **Toxicology (AFMES #184462):**
   A. VOLATILES:
      1. Heart blood positive for methanol (0.149g%) and ethanol (0.020g%).
      2. Liver tissue positive for methanol (0.129g%).
   B. DRUGS: heart blood positive for sertraline (12 ng/mL), citalopram (324 ng/mL), desmethylcitalopram (65 ng/mL), carbamazepine (0.47 mcg/mL), donepezil (72 ng/mL), fentanyl (0.37 ng/mL), and memantine (450 ng/mL).

OPINION

This 82 year old male, Felix Kirkland McDermott, died of exogenous insulin administration. A subcutaneous insulin injection site was identified on the left side of the abdomen.[1] This finding is consistent with the clinical history of a profound hypoglycemic event that occurred the morning of 9 April that was refractory to multiple ampules of D50 solution and 5% dextrose intravenous solution. The deceased was not diabetic and had no history of oral hypoglycemic use or previous insulin administration. There were no hospital orders for administration of insulin. Toxicologic analysis is consistent with embalming and his prescribed medications.

There were multiple co-morbidities that contributed to his overall poor health, including aspiration pneumonia, chronic obstructive pulmonary disease, dementia, and hypertensive atherosclerotic cardiovascular disease. Despite these co-morbidities, he was demonstrating clinical improvement during this hospitalization until this episode of refractory hypoglycemia. This clinical deterioration led to the patient being placed on comfort care measures and he died several hours later.

This case represents the administration of unprescribed insulin to a non-hyperglycemic, non-diabetic patient in a hospital setting. Based on the investigative and autopsy findings, the manner of death is homicide.

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Paul Uribe
LTC, MC, USA
Deputy Medical Examiner

[1] Lutz R, Pedal I, Wetzel C, and Mattern R. Insulin injection sites: morphology and immunohistochemistry. Forensic Science International; 90 (1997); 93-101.